IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

WOODLANDS OUTPATIENT SURGICAL CENTER,
as assignee of Lynda Old,

Plaintiff, CIVIL ACTION NO.

vs. Hon.

AMERICAN BUREAU OF SHIPPING, INC. EMPLOYEE
BENEFIT PLAN;

Defendants.
____/

Orlando L. Blanco
BLANCO WILCZYNSKI, PLLC
Attorneys for Plaintiff
2095 E. Big Beaver, Ste. 400
Troy, MI 48083
(248) 519-9000
____/

COMPLAINT FOR
DAMAGES AND DECLARATORY RELIEF

NOW COMES Plaintiff, WOODLANDS OUTPATIENT SURGICAL CENTER (hereinafter "WOSC"), as assignee of Lynda Old, by and through its attorneys, BLANCO WILCZYNSKI, PLLC, through ORLANDO L. BLANCO, and for its First Complaint for Damages and Declaratory Relief against Defendants, submits the following:

JURISDICTION AND VENUE

1. This is a civil complaint brought under the Employment Retirement Income Security Act of 1974 ("ERISA") as amended, 29 U.S.C. 1001, *et seq.*, specifically ERISA §502 (d), 29 U.S.C. 1132(d), and federal common law, regarding breach of the terms of an employee benefit plan (hereinafter the "Plan") and breach of fiduciary duty, for the purpose of compelling Defendants to provide certain health care benefits

coverage in the amounts and at the coverage levels provided for under the Plan, Declaratory Relief, and for recovery of damages, costs, and attorney fees incurred as a consequence of Defendants' failure to render payment in accordance with the terms of the Plan.

2. This Court has subject matter jurisdiction pursuant to ERISA §§502(e)(1), (f), 29 U.S.C. 1132(e)(1), (f), and 28 U.S.C. § 2201.

3. WOSC brings this action in the District where the breach occurred. Accordingly, venue properly lies in this District pursuant to ERISA §502(e)(2), 29 U.S.C. § 1132(e)(2). In addition, Venue is proper in the United States District Court for the Southern District of Texas, the territory encompassed by the Court where a substantial part of the events giving rise to the lawsuit occurred, pursuant to 28 U.S.C. § 1391(b)(2).

PARTIES

4. WOSC is a corporation organized and existing under the laws of the State of Texas, with its principal place of business in Houston, Texas, specializing in the diagnosis and treatment of sleep deprivation disorders.

5. American Bureau of Shipping, Inc. ("ABS") maintained a benefits plan for the benefit of eligible employees of the Hospital named Defendant "**American Bureau of Shipping, Inc. Employee Benefit Plan**," ("The Plan") which included several component benefit programs, including a "United HealthCare Options PPO Medical Plan." (**Exhibit A, The Plan, Including the United HealthCare Options PPO Medical Plan**).

6. Defendant American Bureau of Shipping, Inc. Employee Benefit Plan was at all times pertinent an employee welfare benefit plan, within the meaning of ERISA §§3(16), 402(a)(2), 29 U.S.C. 1002(16), 1102(a)(2), and federal common law. The Plan

is a welfare benefit plan within the meaning of ERISA §3(1), 29 U.S.C. 1002(1). (**Exhibit A, Section 1.1**).

7. United Healthcare ("UHC"), at all times pertinent, provided services as the third-party administrator for the Plan and does business in Texas. UHC was given the delegated responsibility for determining claims and appeals under the applicable medical component of the defendant Plan, and was also acting as a fiduciary with respect to the Plan within the meaning of ERISA §3(1), 29 U.S.C. 1002(1). (**Exhibit A**).

8. Lynda Old ("Old") was at all times pertinent an employee of ABS and was eligible to participate in the **Plan** and receive benefits under the applicable Medical Plan. (**Exhibit A, Appendix C**). On or about October 8, 2014, Old received medical treatment at WOSC and executed a "**Legal Assignment of Benefits and Designation of Authorized Representative**". (**Exhibit B,** Old's Assignment to WOSC).

GENERAL ALLEGATIONS/FACTUAL BACKGROUND

9. On October 8, 2014, Old was evaluated at WOSC and signed an Assignment of Benefits. (**Exhibit B**).

10. On that same day, Old underwent a surgical procedure/spinal fusion performed at WOSC and WOSC submitted its bill for payment. This procedure was billed to Old's Plan in the amount of $169,661.58, with the coding 63047 and 63048 (indicating laminectomy, facetectomy, and foraminotomy. UHC approved payment of only $7,278.48 of the $169,661.58 actually billed for the procedure, or 4.2% of the billed amount. (**Exhibit C**, Explanation of Benefits dated January 9, 2015).

11. On February 3, 2015, Plaintiff formally appealed the Adverse Benefit Determination by UHC, pointing out that UHC calculated WOSC's fee incorrectly, in

part because it appeared that UHC made its determination as if there was a published Medicare rate for the procedure when, in fact, none existed. (See **Exhibit D**, February 3, 2015 letter from WOSC to UHC).

12. On May 28, 2015, WOSC sent a response letter to Old, not WOSC (WOSC was copied on the letter) was, stating that it "reviewed the appeal filed on your behalf regarding coverages of the service(s) that you received from [WOSC]. . . . Based on our review, according to your Benefit Plan, this request for payment was processed correctly." UHC did not enclose copy of Old's "Benefit Plan," but claimed that the Plan "states that for out-of-network provider these services are covered at 60% of eligible expenses after satisfying [her] annual deductible." UHC further stated that "eligible expenses" (the amount to be reimbursed), was determined based upon the following applicable criteria:

a. Fees that are negotiated with the provider;

b. 110% of the available published rates allowed by Medicare for the same or similar service within the geographic market;

c. a fee schedule that [UHC] develops; or

d. 50% of the billed charge.

No reference was made to a particular section, or page number, of the Plan. (See **Exhibit E**, May 28, 2015 letter).

13. On June 22, 2015, WOSC sent a follow up letter to UHC, requesting a "Second Level Appeal" of the Adverse Benefit Determination, and pointed out to UHC that there was no published CMS/Medicare rate for the services provided to Old, that WOSC expected to be paid for the services provided, and that it was requesting a copy of

the entire Health Benefit Plan document and the Summary Plan Description. (See **Exhibit F**, June 22, 2015 letter).

14. On July 9, 2015, UHC sent WOSC a letter stating that it was in receipt of WOSC's appeal and that WOSC did not need to respond to the letter. UHC also stated that WOSC would receive a decision regarding the appeal within 30 days. (**Exhibit G**).

15. On July 22, 2015, UHC responded to Old, not WOSC. UHC repeated the same initial reasons for the denial of benefits, adding now that "eligible expenses are determined solely in accordance with ***our reimbursement policy guidelines***," (emphasis added) and listed the following four criteria for determining the benefits:

a. As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services ("CMS");

b. As reported by generally recognized professionals or publications;

c. As used for Medicare; and

d. As determined by medical staff and outside medical consultants pursuant to other appropriate source, or determination that we accept.

(See **Exhibit H**, June 22, 2015 letter from UHC to Old). While UHC claimed that this methodology for determining benefits came from the Summary Plan Description, or "SPD," it did not provide a citation to any chapter, section, or page number of the SPD. In fact, upon review of the SPD/booklet ABS sent to Plaintiff, the methodology used by UHC is denying/limiting the claim does not exist.

16. On August 8, 2015, UHC sent Old, not WOSC, a letter, enclosing the following documents, which it claimed were "used in making the determination" to pay only $7,278.48 of the $169,661.58 claim:

a. Claim Processing;

b. Explanation of Benefits;

c. Resolution Letter; and

d. Appeal Request.

(See **Exhibit I**, August 8, 2015). This cannot be correct, as the Explanation of Benefits, Resolution, and Appeal Request were all generated *after* the decision to deny full payments of benefits had been made and could not have been used in *making* the determination. Additionally, UHC denied WOSC's request for copies of Plan Documents and the SPD, stating that UHC does not provide the requested documents (the Plan and SPD) as part of its function to provide "administrative services" under the Plan. (**Exhibit I**, highlighted portion).

17. In December of 2015 and January of 2016, ERISA Claims Specialists ("ECS"), an entity retained by WOSC to recover illegally denied benefits such as this one, and Justin Hall, counsel for UHC, engaged in an exchange of emails which revealed the following information:

a. Mr. Hall forwarded a copy of the Plan (the WRAP document referenced) dated 2003, as well as the SPD;

b. There had been no amendments to the Plan since 2003 (as of January 22, 2016, the date of Mr. Hall's email to ESC);

c. The SPD, which is dated January 1, 2012, was applicable to Old's surgery in 2014 and the subsequent request for payment/claim. Hall stated this even though the January 1, 2012 SPD was not adopted by the Plan's amendment procedure into the Plan.

(**Exhibit J**, emails).

18. On February 11, 2016, ERISA Claims Specialists sent ABS an "Internal Appeal of Claim Denial under ERISA §2560.503-1(m)(4) & PPACA Regulations: (a)(b) of 26 CFR 54.9815-2719T, 29 CFR 2590.715-2719, 45 CFR 147." ECS told UHC that it

was incorrect in its denial of the claim because, contrary to UHC's representations, the Plan was/is silent as to the "maximal allowable amounts payable for covered medical services" and that UHC had processed the claim pursuant to an undisclosed Administrative Services Only agreement and not according to any applicable SPD. As a result, UHC decided the claim based on terms which had not been adopted into the Plan and were external to the Plan, contrary to ERISA requirements. (See **Exhibit K**, February 11, 2016 Appeal).

19. On March 4, 2016, Justin Hall, Senior Counsel for ABS, responded to ECS' appeal on behalf of the Plan and stated the following:

a. UHC, in its capacity as claims administrator, paid the portion of what it considered to be the eligible expenses under the Plan;

b. After Old assigned her claim to WOSC, which engaged ECS to appeal the matter, which was denied by UHC "upon two levels of review."

c. As an out of network provider, WOSC was entitled to 70% of "eligible expenses." This was despite the initial UHC denial letter stating that the Plan pays 60% of the "eligible expenses." The 2012 booklet ABS held out as the binding terms of the plan states the Plan pays 70% of the eligible expense. Thus, ABS certified that the documents relied upon by UHC are and were different than what ABS certified as binding terms of Plan. In addition, ABS had been changing the plan year after against the direct amendment procedures of the plan.

d. Hall then listed the criteria for determining "eligible expenses." That criteria differed substantially from the criteria listed in the paragraphs above. The criteria Hall listed is as follows:

1. 50% of published rates allowed by the Centers for Medicare and Medicaid Services (CMS);

2. When a rate is not published by CMS, use of an available "gap methodology;"

e. Hall then concluded that "this language is consistent with the basis for denial provided by" UHC, even though the criteria Hall listed is different than the criteria used by UHC as certified by UHC in its two appeal denial letter to deny the claim.

(See **Exhibit L**, Justin Hall March 4, 2016 Letter). UHC has consistently referred to sections of multiple SPD's/booklets, establishing that it relied on multiple documents which were never properly incorporated into the plan.

20. On April 4, 2016, ECS responded to Mr. Hall's letter by stating:

a. The Plan is silent as to the "maximal amount of benefits allowable under the plan" because Section 7.10 of the Plan required the Board of Directors of ABS or a representative to make changes to the Plan, which was not done in this case;

b. As a result of the Board of Directors failure to amend the Plan to adopt any SPD, the full amount of the procedure issue is payable.

c. Finally, the Plan and UHC had been relying on terms which were external to the Plan in denying the benefits due and owing for the October 8, 2014 procedure.

(See **Exhibit M**, ECS April 4, 2016 Response).

COUNT I - ACTION UNDER ERISA §502(A)(1)(B), 29 U.S.C. 1132(A)(1)(B) AND FEDERAL COMMON LAW TO RECOVER BENEFITS AGAINST ALL DEFENDANTS

21. Plaintiff re-alleges and incorporates all foregoing paragraphs.

22. Pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B), Plaintiff seeks to recover benefits due under the terms of the Plan, to enforce rights under the terms of the Plan and to clarify rights to future benefits under the terms of the Plan. Specifically, Plaintiff was wrongfully and improperly denied benefits by Defendants which are clearly reimbursable under the Plan, including benefits for past and future medical care provided under the Plan.

23. ERISA requires every employee benefit plan to be established and maintained pursuant to a written instrument, 29 U.S.C. §1102(a)(1), specifying the basis on which payments are made to and from the Plan. 29 U.S.C. §1102(b)(4). A plan administrator is obligated to act in accordance with the governing written plan under the provisions of 29 U.S.C. §1104(a)(1)(D). Claims under an employee welfare benefit plan governed by ERISA are determined according to the terms of the Plan itself. 29 U.S.C. §1132(a)(1)(B). Summary documents providing communications with beneficiaries about the Plan do not constitute the terms of the Plan. *Cigna Corp. v. Amara,* 131 S. Ct. 1866 (2011).

24. Plaintiff made a timely claim for benefits under Defendants' ERISA Plan and fulfilled all requirements under the Plan. Defendants wrongfully denied benefits due to Plaintiff under the terms of the Plan in one or more of the following ways:

a. Wrongfully denying benefits which are clearly reimbursable under the terms of the Plan itself.

b. Wrongfully denying benefits reimbursable under the Plan based on fraudulent misrepresentations made by Defendants that (a) the 2012 SPD was a controlling document to determine benefits and (b) that benefits were payable at a reduced rate based on documents which were external to the Plan; and (c) that benefits were payable at a reduced rate which has not, to date, been explained to Plaintiff; that is, based on three different sets of criteria, none of which explain the reduced rate ultimately paid by Defendants.

c. Alternatively, and to the extent that an internal document is considered to having been legally incorporated into the Plan, denying customary and reasonable charges for the procedure even though the Plan requires payment. That is, even though the 2012 SPD has not been properly adopted and incorporated into the Plan, the methodology used by Defendants in paying a significantly reduced rate is based on three different sets of criteria, none of which justify the reduced rate.

d. Failing to timely provide Plaintiff with an accurate explanation of benefits and basis of denial of benefits under the Plan and continuing to mislead Plaintiff as to the true nature of the benefits reimbursable under the Plan.

e. Failing to timely provide Plaintiff with a copy of all pertinent Plan documents when requested as required by 29 U.S.C. § 1022 and other controlling provisions of ERISA.

f. Failing to provide for a full and fair review of the denial of Plaintiff's claim for benefits are required by 29 U.S.C. § 1133; 29 C.F.R. 2560.503-1(h)(2)(i)-(iv).

g. Refusing to pay for medical services rendered which are authorized and reimbursable under the Plan.

h. Intentionally misconstruing and misrepresenting provisions of both the Plan, as well as other internal documents relied upon for the denial of benefits in order to deny benefits that are clearly reimbursable under the terms of the Plan.

i. Other wrongful acts and/or omission that may be developed during discovery.

j. ABS stated that it would not provide documents to plaintiff, even though it was required to do so, instead telling plaintiff that it delegated this task to UHC. UHC said it was not UHC's job to produce the information. This is contrary to ABS' prior correspondence to Plaintiff, in which it certified that the claims were correctly processed. To date, ABS has refused to identify any documents or methodology by which the claim was denied.

25. Defendants' denial of Plaintiff's claims for benefit payments is in direct violation of the terms of the Plan. Specifically, Plaintiff's claims were wrongfully denied, for all of the reasons noted above.

26. Therefore, pursuant to the terms of the Plan, and ERISA § 502(a)(1)(B) and 29 U.S.C. §1132(a)(1)(B), Plaintiff hereby seeks recovery of the full benefits due for the services rendered, together with costs and attorney fees wrongfully incurred in having to pursue this claim, despite reasonable attempts to resolve this matter prior to suit.

COUNT II - ERISA ESTOPPEL
BASED ON FEDERAL COMMON LAW

27. Plaintiff re-alleges and incorporates all foregoing paragraphs.

28. Pleading in the alternative, without waiving any of the foregoing allegations, and pursuant to equitable principles recognized under federal common law, more commonly referred to as "ERISA Estoppel", that Defendants are estopped from denying Plaintiff's claim for benefits under the Plan in order to prevent Defendants from benefiting from their own misleading conduct, based upon a course of conduct and dealing between the Plan, its agents and representatives and Plaintiff, a medical provider, as more fully set forth in paragraphs 1-20, including but not limited to the following:

a. After performing the procedure on October 8, 2014, Plaintiff repeatedly attempted for months to obtain payment for its services, including filing several internal appeals which expressly requested that Defendants provide payment for the procedure on the grounds that the procedure was covered by the Plan. During this time, Defendants arbitrarily and capriciously denied Plaintiff's claim for benefits/payment pursuant to the Plan.

b. In addition, UHC communicated to Plaintiff, several times, as outlined above, that the payment it made was appropriate, without identifying in what way, or pursuant to what documents/pages, the Plan or SPD called for minimal payment.

c. Due to their course of conduct, as more fully described in the foregoing paragraphs of this Complaint, including misrepresentations about the terms of the Plan, Defendants have waived and are estopped from relying on documents not incorporated into the Plan, as a basis to deny the claim.

d. Specifically, Defendants considered two levels of appeals from Plaintiff, changed the criteria for its denial of benefits on three occasions, and relied on documents which were not properly incorporated or adopted into the Plan, and failed to produce documents which were mandated by ERISA.

29. Extraordinary circumstances exist to support Plaintiff's claim for ERISA Estoppel based on Defendants acts of intentional, misleading, reckless and otherwise malicious misrepresentation with respect to the benefits due under the terms of the Plan, in the manner more fully described in the foregoing paragraphs, including but not limited to:

a. Wrongfully denying Plaintiff's claim for benefits under the Plan without a reasonable basis for such denial.

b. Misrepresenting the terms of the Plan and other documents for the specific purposed of misleading Plaintiff and others about benefits under the Plan.

c. Misrepresenting the terms of an internal document for the specific purpose of denying benefits otherwise covered and reimbursable under the terms of the Plan.

d. Failing and refusing to conduct a full and fair review of Plaintiff's claim for benefits and appeal, and claiming to have conducted such reviews, when Defendants knew that this was not true, violating 29 C.F.R. 2560.503-1(h)(i)-(v) as well as other provisions of ERISA.

e. Committing acts of bad faith, concealment and fraud by misrepresenting the terms of the Plan, relying and communicating to Plaintiff language from internal documents that Defendants knew did not constitute the terms of the Plan, and even misrepresenting the terms of internal documents for the specific purpose misleading Plaintiff into believing that services rendered were not covered by the Plan.

f. Preventing particularly vulnerable claimants and beneficiaries such as Plaintiff, Old and other beneficiaries from seeking benefits for medical procedure reimbursable under the Plan by misleading them about the terms of the Plan and the coverage for certain vital services such as the procedure at issue.

g. Engaging in unconscionable and otherwise fraudulent conduct under both Federal Common law and State law, including but not limited to the Texas Deceptive Trade Practices Act, section 17.50 (a)(3) and other violations of the Texas Insurance Code, as well as other state laws that may serve as grounds for equitable relief under ERISA.

h. Defendants actively engaged in acts to conceal significant facts including that the fact that they were not relying on the terms of the Plan itself for denial of benefits, despite representations to the contrary, that they were instead relying on internal documents that had never been legally incorporated into the Plan, as required by the term of the Plan itself and even misrepresented the complete pertinent terms of the internal documents that Defendants claimed to be relying on to deny benefits.

i. Other acts or omission that may serve to establish grounds for equitable relief that may be developed in discovery.

30. Pursuant to ERISA Estoppel, Plaintiff seeks to enjoin the above-described acts and practices which violate ERISA and the terms of the Plan and to obtain all other appropriate equitable relief to redress such violation and enforce the terms of the Plan, including but not limited to all of the following:

a. Estopping Defendants from Plaintiff's benefits under the Plan.

b. Monetary compensation for losses resulting from Defendants' wrongful conduct and unjust enrichment included an equitable surcharge to the extent permitted by law.

c. To the extent necessary, Reformation of the Plan to include for payment of reasonable and customary benefits as represented.

d. Any and all equitable remedies to remedy breaches of fiduciary duties by Defendants.

COUNT III – RELIEF REQUESTED
UNDER ERISA AND FEDERAL COMMON LAW

31. Plaintiff re-alleges and incorporates all foregoing paragraphs.

32. As a direct result of Defendants' wrongful conduct, as more fully described above, Plaintiff has suffered the following damages:

a. Non-payment of benefits reimbursable under the Plan.

b. Damage to Plaintiff's credit and reputation.

c. Delay and/or denial of reasonable and necessary medical care to patient.

d. Loss of monetary interest for payments due and owing under the Plan.

e. Mental anguish in the past and into the future.

f. Consequential and incidental damages.

g. Attorney fees as provided by 29 U.S.C. §1132 and by federal or state common law.

h. Statutory penalties for failure to comply with ERISA's statutory requirements.

i. Punitive damages to the extent permitted by federal common law for ERISA Estoppel claims.

j. All other damages as allowed by law.

33. Plaintiff seeks to recover past and existing benefits due under the terms of the ERISA plan. Plaintiff requests that this court clarify Plaintiff's rights to future

benefits under the terms of Defendants' ERISA Plan and seeks monetary damages for Defendants' breach of its obligation to pay Plan benefits, as well as other wrongful actions, together with all equitable relief provided under ERISA and federal common law, including, but not limited to, the equitable remedy of reinstatement of benefits due under the Plan, the payment of benefits owed to Plaintiff under the Plan, and all other equitable relief to make Plaintiff whole, as allowed by law.

34. Plaintiff also pleads for extra contractual damages in connection with Plaintiff's ERISA Estoppel claims, including, but not limited to, consequential and incidental damages in the past, present, and future permitted under this ERISA Estoppel claim.

35. Defendants acted intentionally, knowingly, recklessly, and with malice, in interfering with Plaintiff's right to benefits under the Plan. Accordingly, Plaintiff seeks punitive damages in connection with its ERISA Estoppel claims against Defendants for their willful, intentional, and malicious conduct, to the extent such damages are allowed by law and/or to preserve the issue for potential appellate review.

36. Plaintiff seeks pre-judgment interest on all monies retained by the Plan that rightfully belong to Plaintiff, which have allowed Defendants to profit from their wrongful acts that would amount to unjust enrichment. Plaintiff seeks all other pre-judgment and post-judgment interest at the maximum rate allowed by law.

37. Plaintiff requests that this court award reasonable attorney fees and costs, as provided for under ERISA and federal common law.

PRAYER FOR RELIEF

WHEREFORE, PLAINTIFF REQUESTS that the Court grant the following relief:

a. a declaratory judgment pursuant to ERISA §502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B), and 28 U.S.C. 2201, declaring that Plaintiff is entitled to payment of the full benefits in the proper amounts as set forth in the Plan in effect at the time benefits became payable and that Defendants have violated the Plan and its fiduciary duties by denying these benefits;

b. preliminary and permanent injunctions pursuant to ERISA §502(a)(3), 29 U.S.C. 1132(a)(3), and Fed R Civ P 65, enjoining Defendants from denying, reducing, limiting, or terminating the benefits payable to Plaintiff under the Plan;

d. an order compelling Defendants to pay Plaintiff forthwith the full amount of health benefits due and to continue such payments for the period set forth in the Plan, including interest on all unpaid benefits;

e. disgorgement of any profits or gain Defendants have obtained as a result of the wrongful action alleged in this complaint and equitable distribution of any profits or gain to Plaintiff;

f. reasonable attorney fees and costs, pursuant to ERISA §502(g)(1), 29 U.S.C. 1132(g)(1); and

g. such other relief as may be just and appropriate.

Respectfully submitted,

BLANCO WILCZYNSKI, PLLC

/s/ Orlando L. Blanco
Orlando L. Blanco
2095 E. Big Beaver, Ste. 400
Troy, MI 48083

Dated: May 12, 2017

JURY DEMAND

Plaintiff hereby requests a trial by jury on all questions of fact related to Plaintiff's claims as pled above.

Respectfully submitted,

BLANCO WILCZYNSKI, PLLC

/s/ Orlando L. Blanco
Orlando L. Blanco
2095 E. Big Beaver, Ste. 400
Troy, MI 48083

Dated: May 12, 2017